Optimizing Health Reform to Improve Maternal and Infant Health Outcomes

Sunday, February 10, 2013

1:30 – 3:00PM

Optimizing Health Reform to Improve Maternal and Infant Health Outcomes: **Mississippi Activities**

Juanita Graham, DNP, RN, FRSPH

Mississippi State Department of Health

Issue

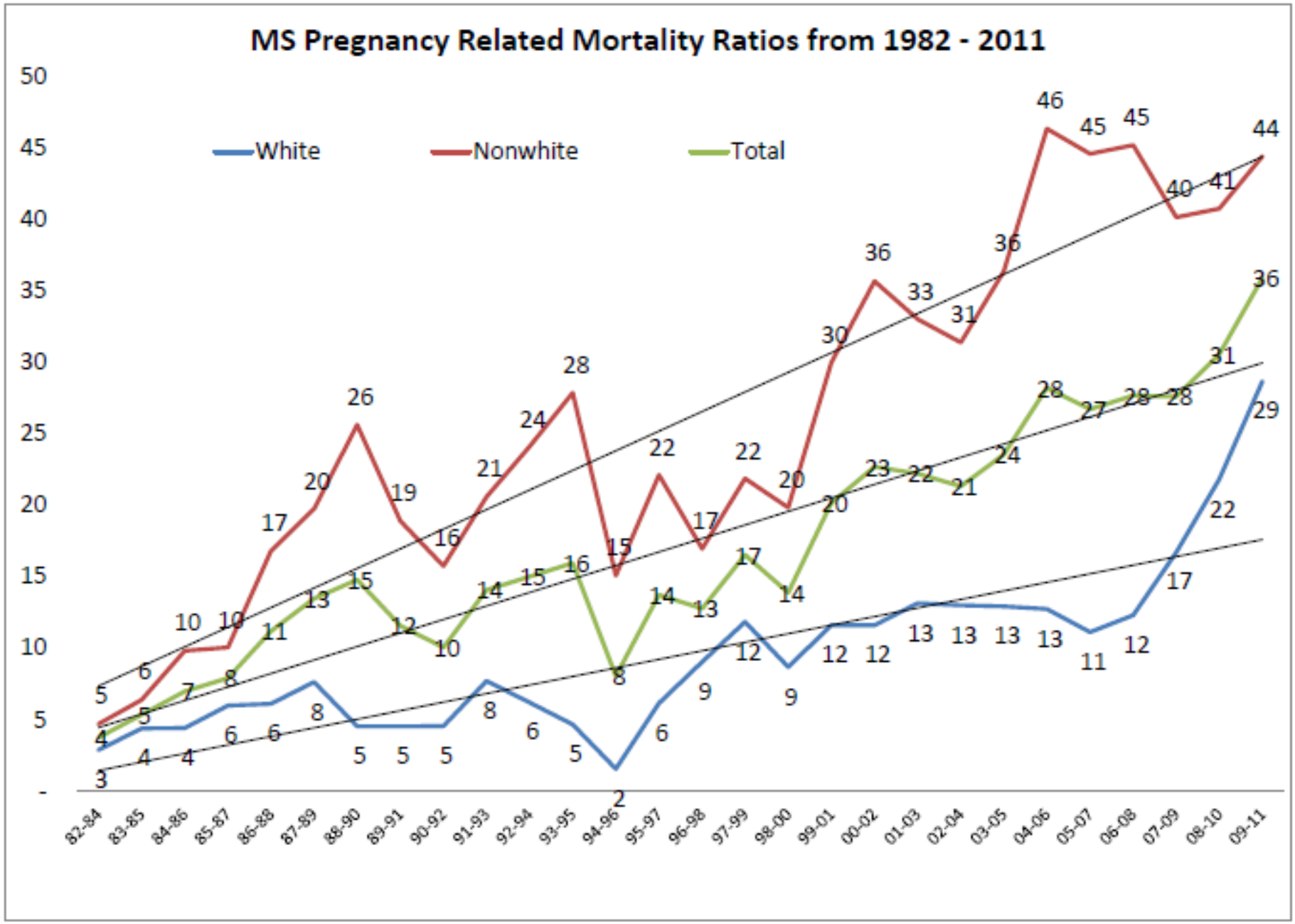
- MS historically leads the nation in the rate of infant morbidity and mortality
- Primary causes are low birth weight and premature birth, birth defects, Sudden Infant Death Syndrome (SIDS), accidents and maternal complications of pregnancy
- Also, leads the nation in rate of pregnancy-associated maternal mortality

Infant Mortality Rates

2011	US	MS
Black, non Hispanic	11.4	13.2
Total	6.0	9.4
White, non Hispanic	5.1	6.5

Pregnancy-Associated Maternal Mortality Rates

2011	US	MS
Black, non Hispanic	25.6	28.4
Total	11.8	13.1
White, non Hispanic	9.5	10.5


MS Pregnancy Related Mortality Ratios from 1982 - 2011
White
Nonwhite
Total
50
45
40
35
30
25
20
15
10
5
-
82-84
83-85
84-86
85-87
86-88
87-89
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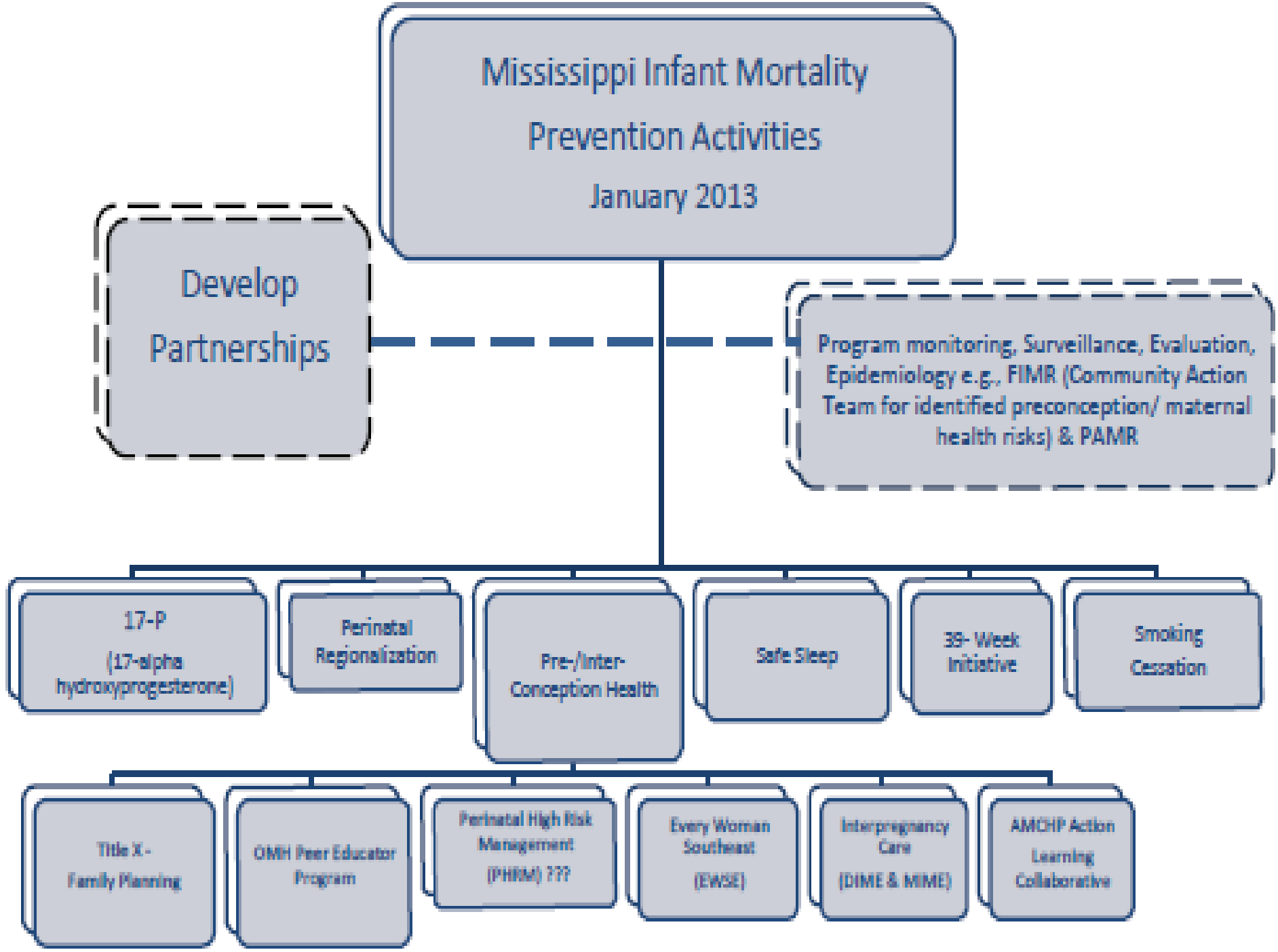
Mississippi Infant Mortality Prevention Activities January 2013
Develop Partnerships
Program monitoring, Surveillance, Evaluation, Epidemiology e.g., FIMR (Community Action Team for identified preconception/ maternal health risks) & PAMR
17-P (17-alpha hydroxyprogesterone)
Perinatal Regionalization
Pre-/Inter-Conception Health
Safe Sleep
39- Week Initiative
Smoking Cessation
Title X - Family Planning
OMH Peer Educator Program
Perinatal High Risk Management (PHRM) ???
Every Woman Southeast (EWSE)
Interpregnancy Care (DIME & MIME)
AMCHP Action Learning Collaborative

IM Reduction Activities

- 17-P
- Perinatal Regionalization / Risk Management
- Safe Sleep
- 39-Weeks Initiative
- Smoking Cessation / Smoke Free Air
- Pre/Interconception Care

Pre/Inter-Conception Care Activities

- Title X / Family Planning
- OMH Peer Educator Program
- Every Woman Southeast (EWSE)
- AMCHP Action Learning Collaborative
- PHRM/ISS
- Mississippi IPC: Dime & MIME

Strategic Direction

- Blending preconception health into existing programs and protocol

Challenges

- Competing projects with limited resources
- Medicaid changes i.e. PHRM
- Systems / transportation issues
- Moving from fragmented to blended and integrated activities
- "Unknown" related to ACA portions MS will / will not participate in

Lessons Learned

- Instead of creating new programs, improve or build on established programs
- Blend / share resources & activities across programs
- Need to establish a solid evaluation plan from start including methods for carrying out the evaluation plan

Success Stories

- DIME & MIME nearing completion of client 2-year follow up
- FIMR Pilot
- PAMR Pilot

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Optimizing health care reform

to improve birth outcomes and women's health in New Mexico

Creating community linkages and partnerships to reduce unintended pregnancy, elective c-sections, preterm birth

February 10, 2013

Eirian Coronado, MA
New Mexico Department of Health

Acknowledgements

Action Learning Collaborative members:

Emelda Martinez, MCH Title V Director

April Neri, Family Planning Program, Title X

Jonah Garcia, LCDF Healthy Start, Dona Ana County

Dr. Janis Gonzales, Children's Medical Services

Denita Richards, Maternal Child Health/Midwifery

Sallyanne Wait, Medicaid Pregnancy Program

‘Expansion’ in New Mexico

- NM Legislature considering raising 133% FPL to 138% for full Medicaid coverage eligibility
- As of August, 2012 women eligible for prevention screenings/counseling without co-pays
- >$34 million received in grants to establish affordable insurance exchange
- $1 million received for planning grants (research)
- >$4 million received for Community Prevention (chronic disease, wellness programs)

Source: HealthCare.Gov- updated October, 2012

What does this mean?

- Local coalition building and workforce is imperative
- Partnerships are key, and 'para'-professionals such as Community Health Workers/Promotores must be at the table
- Health Provider Shortage areas will not keep up with demand unless effective linkages between community and health agency- Medicaid agency collaboration

Goals of NM ALC Collaboration

Optimize partnerships to proactively plan for & adapt to impact of ACA

- Summarize prevalence of birth outcomes, prenatal care utilization, exclusive breastfeeding to 6 months
- Map services and resources- as well as perinatal risks- to assess for gaps in service
- Develop clinical and encounter-based linkages to track care by perinatal period and 0-3 childhood

DOH Collaboration with HSD Medicaid

- Reducing unintended and teen births 2003
- Perinatal Depression screening (standardize) 2008
- Folic acid- preconception screening/counseling 2010
- 'Hard-stop' on elective C-section for Medicaid deliveries 2013
- Reduce preterm deliveries
- Promote safe sleep environments for infants

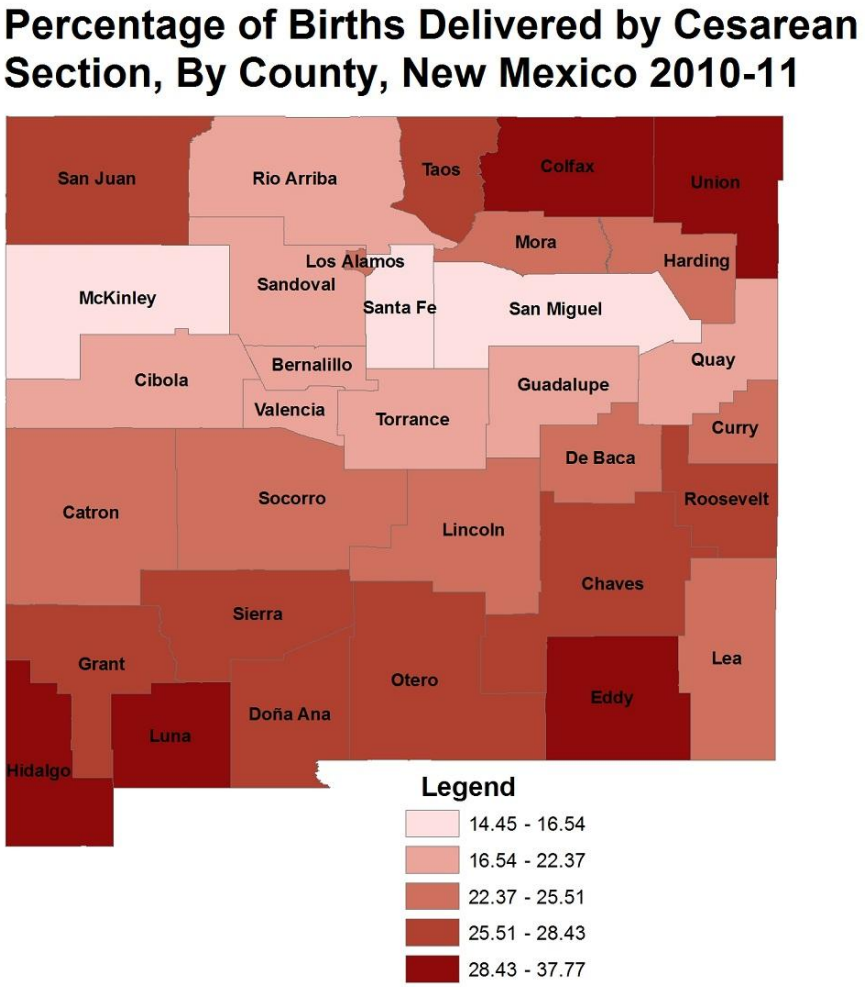
Births in New Mexico

- 23% of resident live births delivered by C-section (2011)
- The Birthing Workforce Retention Fund caps malpractice insurance for licensed midwives;
- I.H.S. C-section rates remain low and they lead NM in VBAC deliveries
- Medicaid and HMO companies lag behind

http://www.nytimes.com/2010/03/07/health/07birth.html?pagewanted=all&_r=0

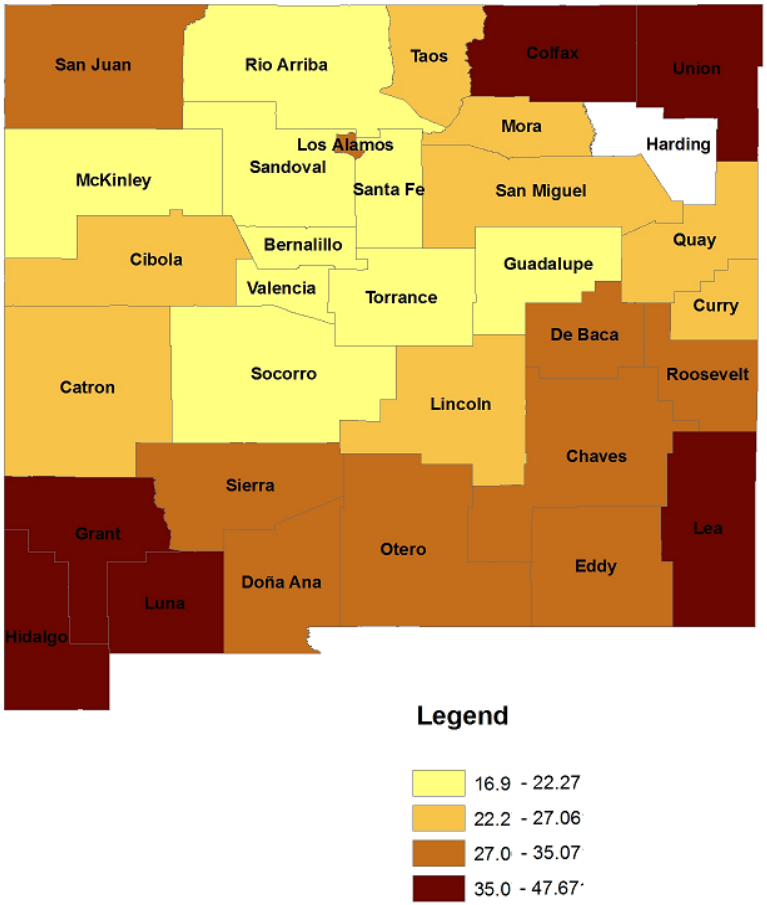
data source- NM Vital Records Epidemiology file 2011 births

C-section prevalence levels, by County of maternal residence NM

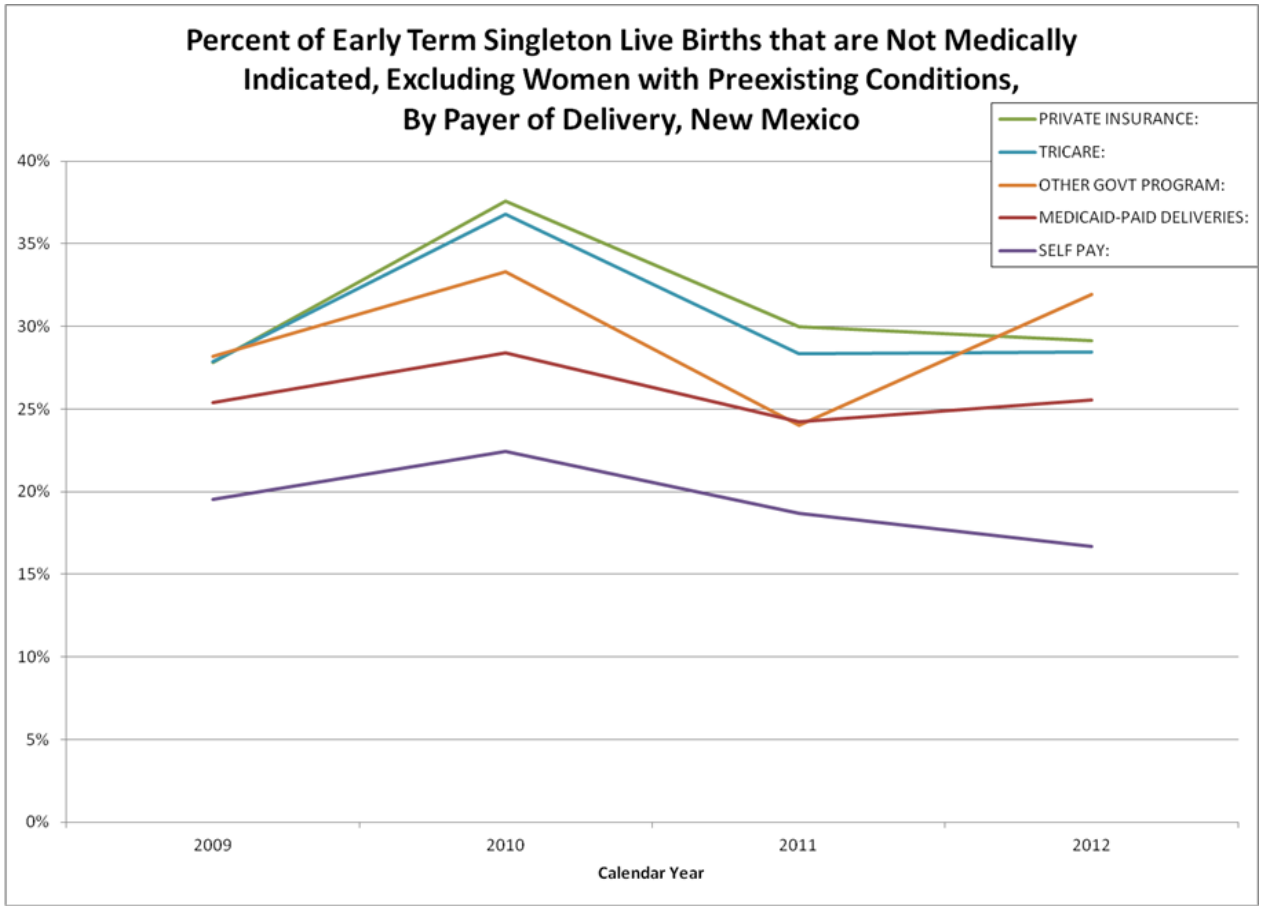


Non-medically indicated C-sections, by County of maternal residence NM

Percent of early term singleton live births that are not medically indicated, excluding women with preexisting conditions, New Mexico 2009-2012.



Non-Medically indicated C-sections by Payer



Elective C-section prevention effort strategies

- Collaborate with Human Services Department (HSD) to identify measures, goals and targets to define policy on non-payment for elective deliveries prior to 39 weeks gestation
- Stipulate policy in Medicaid Managed Care Organizations (MCO) contracts
- Work with the March of Dimes and UNMH on the 38 weeks – Baby worth the wait toolkit

http://www.marchofdimes.com/professionals/medicalresources_39weeks.html

The 'Hard stop'

Effective April 1, 2013

rule NMAC 8.301.3 was revised so that Medicaid deliveries would not be reimbursed at C-section rate if providers did not meet the medically-indicated criteria for induction or C-section delivery:

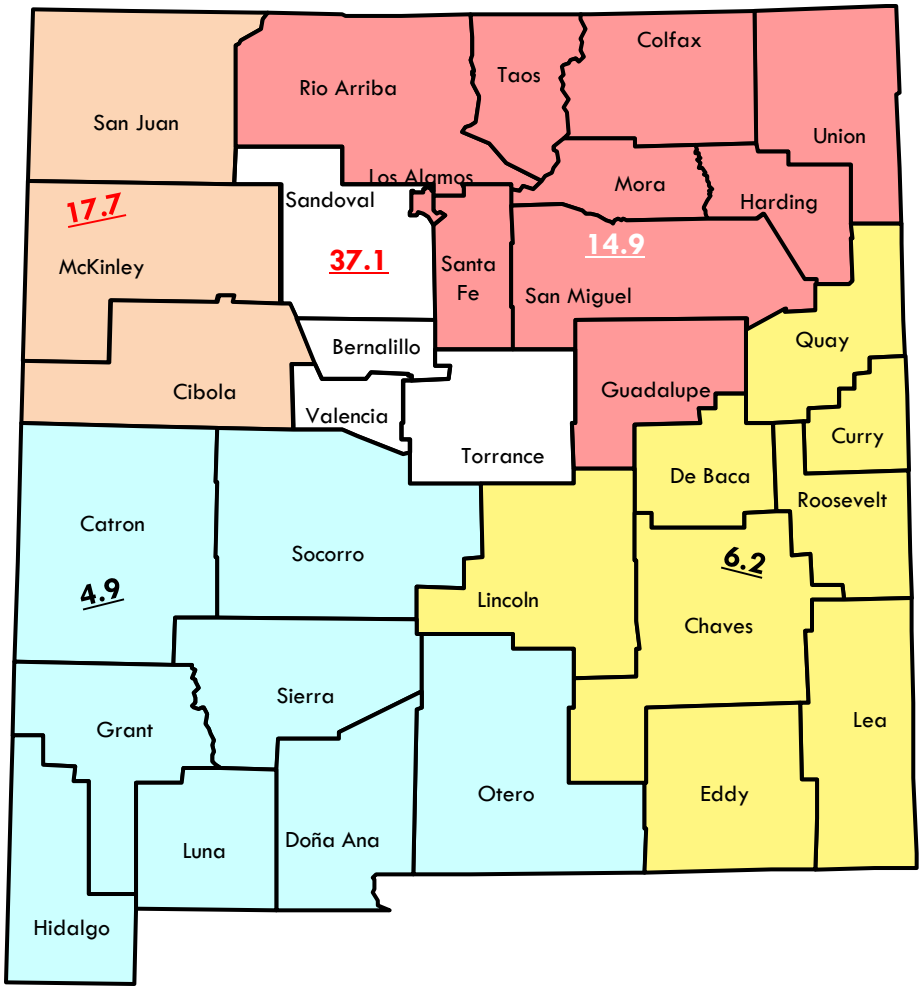
-39 weeks gestation with medical justification

- qualifying medical condition present using specified codes, as delineated in rule

- fetal lung maturity not established

Records are subject to retrospective review and to payment recoupment; failure to apply U1 results in 'vaginal' rate

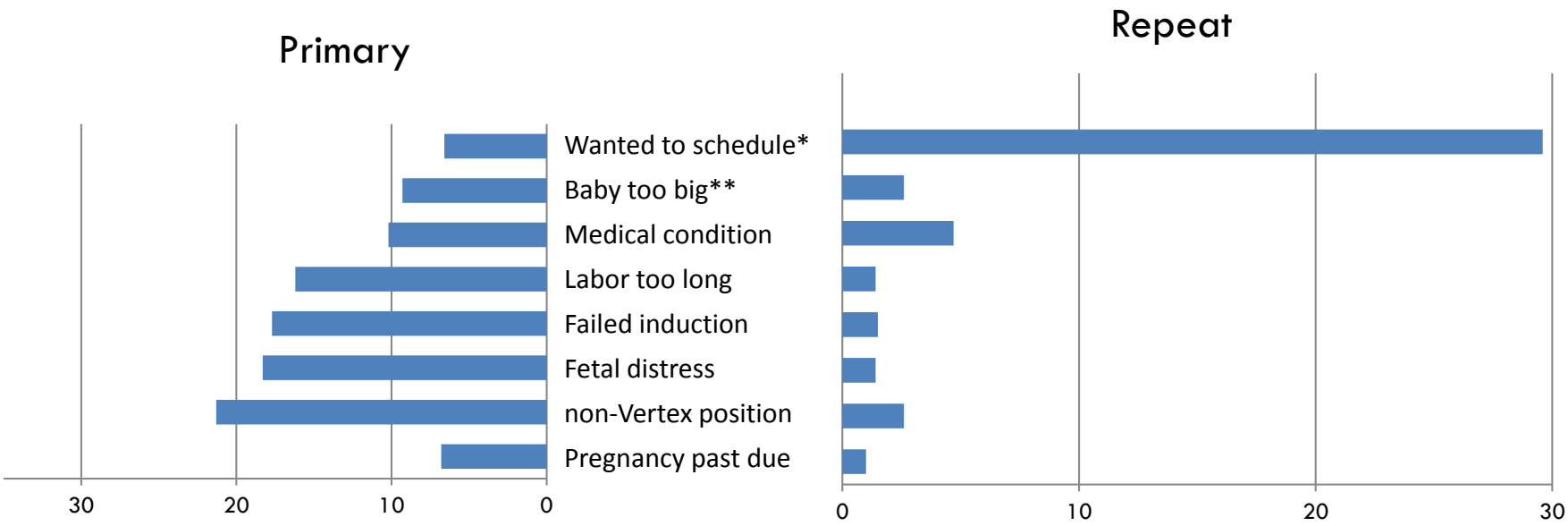
Percent of VBAC deliveries by Public Health region (among previous C-sections) 2009-2011



But…

- Hospital billing and Medicaid reimbursement are one piece of the puzzle- (ex. VBAC is not offered)
- The private insurance companies are not held to the same standard, YET
- Previous C-section is considered a medical indication
- Fear about giving birth and adverse delivery outcomes are generated by physicians, nurses, and family

Self-reported reasons for C-section



NM PRAMS 2009-2010 births, responses not mutually exclusive

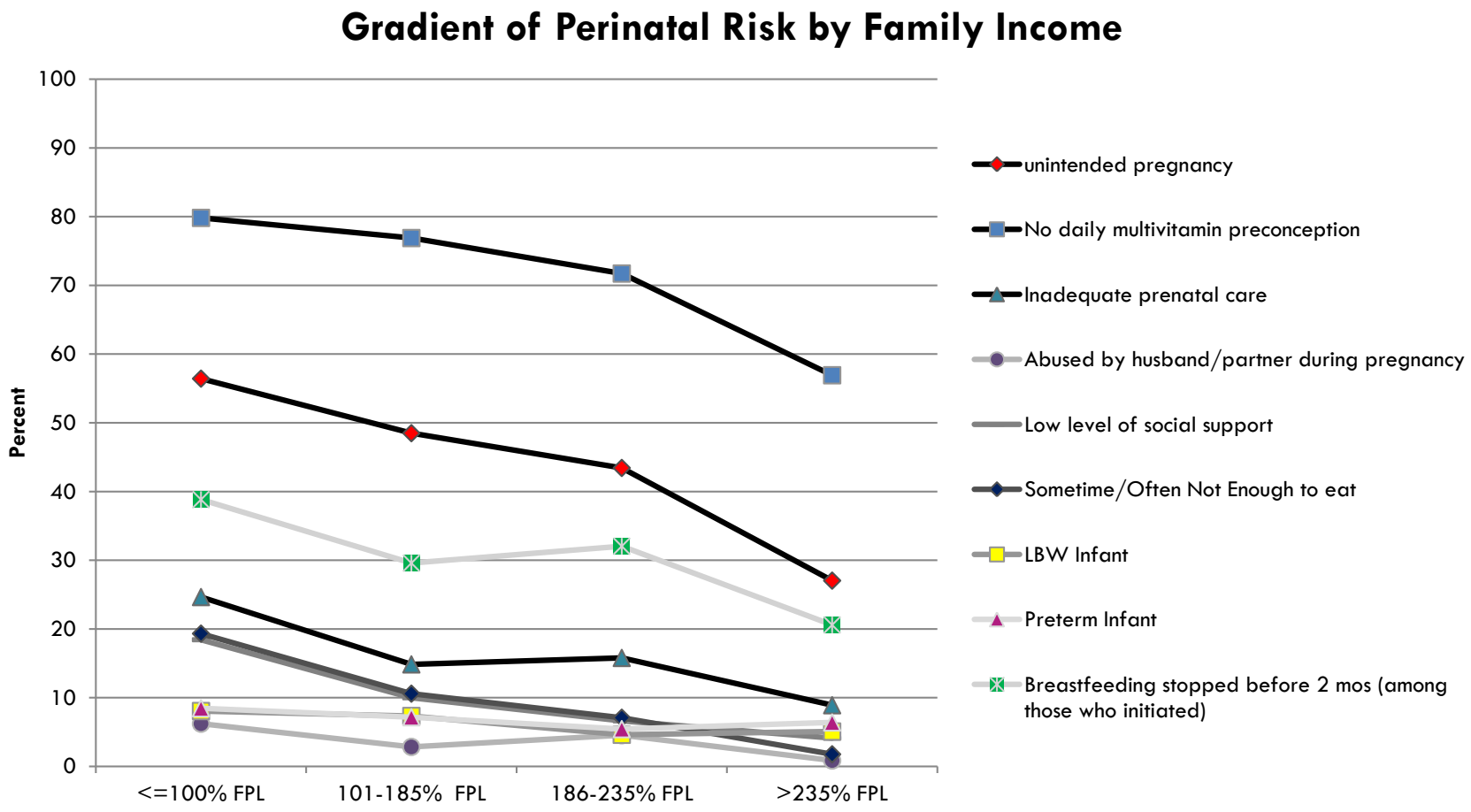
* Mom wanted to schedule delivery or did not want to deliver vaginally

* *provider assessment

What's next?

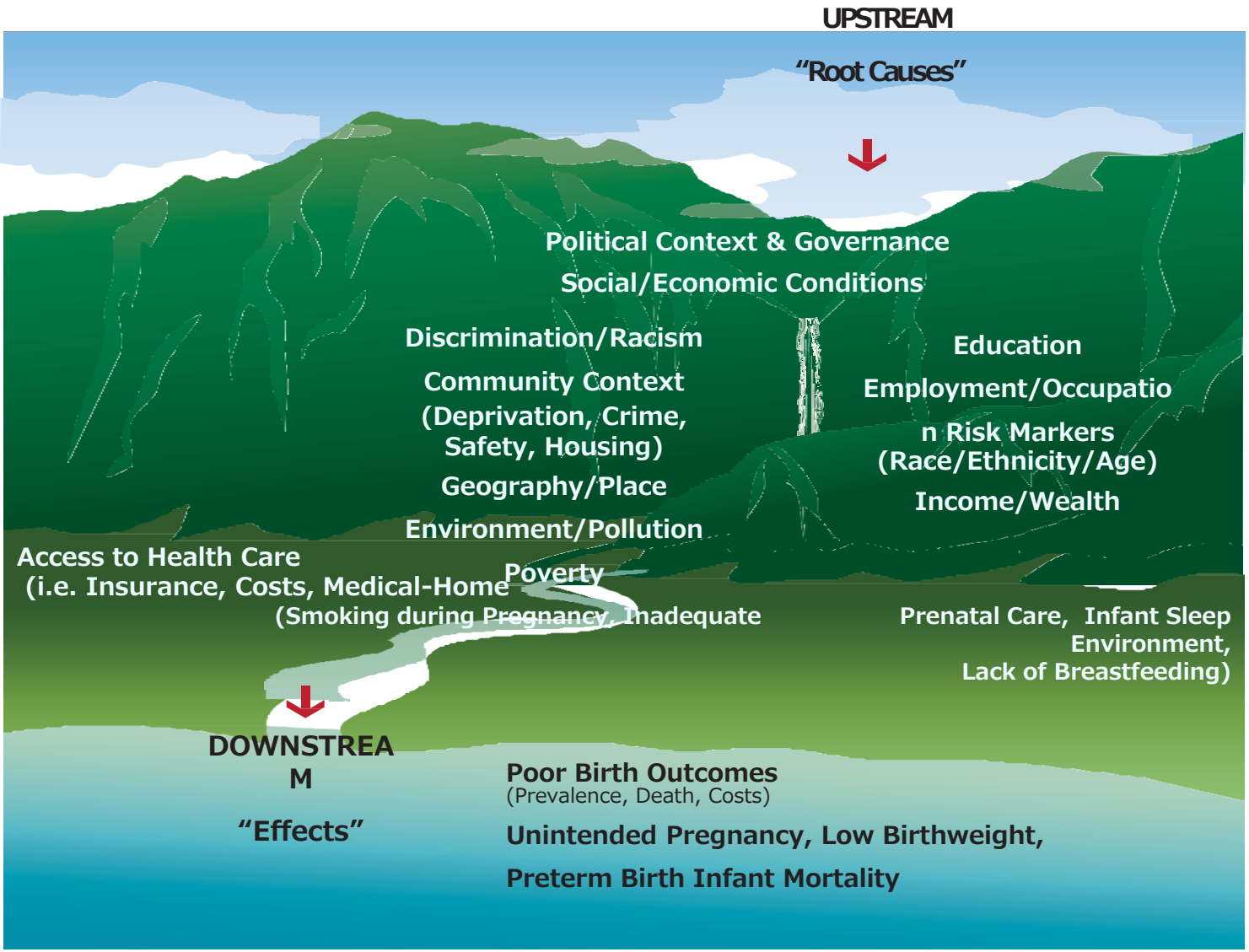
- Increasing capacity for doulas for delivery and breastfeeding support are crucial at hospital and in community
- Some of the antecedents for C-section: diabetes, hypertension, preeclampsia, even premature rupture of membranes should be avoidable and demand a deeper intervention
- Standardized depression and violence screening to include motivational interviewing

Selected risks by federal poverty level



NM PRAMS 2009-2010 births

SOCIAL DETERMINANTS OF HEALTH



Visual Based on : Chronic Disease Burden Report HAWAI'I STATE DEPARTMENT OF HEALTH

Summary

- New Mexico has a long history of partnership between the Department of Health, Public Health Division and the Human Services Department, Medical Assistance Division
- Common goals were established or revised collaboratively
- Action was taken- however many gaps left
- The ALC is our opportunity to mobilize and strategize to close the gaps

Thank You!

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Program Contact Information, NMDOH

Thank You!

Sunday, February 10, 2013

1:30 – 3:00PM

Title V and Its Role in the Implementation of the Affordable Care Act
February 10, 2013

Carolyn McCoy, MPH Senior Policy Manager, AMCHP

Session Objectives

Primary Objectives

Attendees will:

Increase understanding of key provisions of the ACA that have been implemented in the last year.

Increase knowledge of key provisions of the ACA that will be implemented in 2013, 2014.

Describe the role that states have now and in the future of implementation of the Affordable Care Act and the impacts on MCH populations.

Identify the various opportunities, challenges and lessons learned from a variety of state perspectives.

Secondary Objectives

Attendees will:

Feel more informed of other state leaders' participation in the implementation of the ACA as well as their role in the state-level implementation process and ensure that MCH populations are included in discussions relating to the implementation of the ACA.

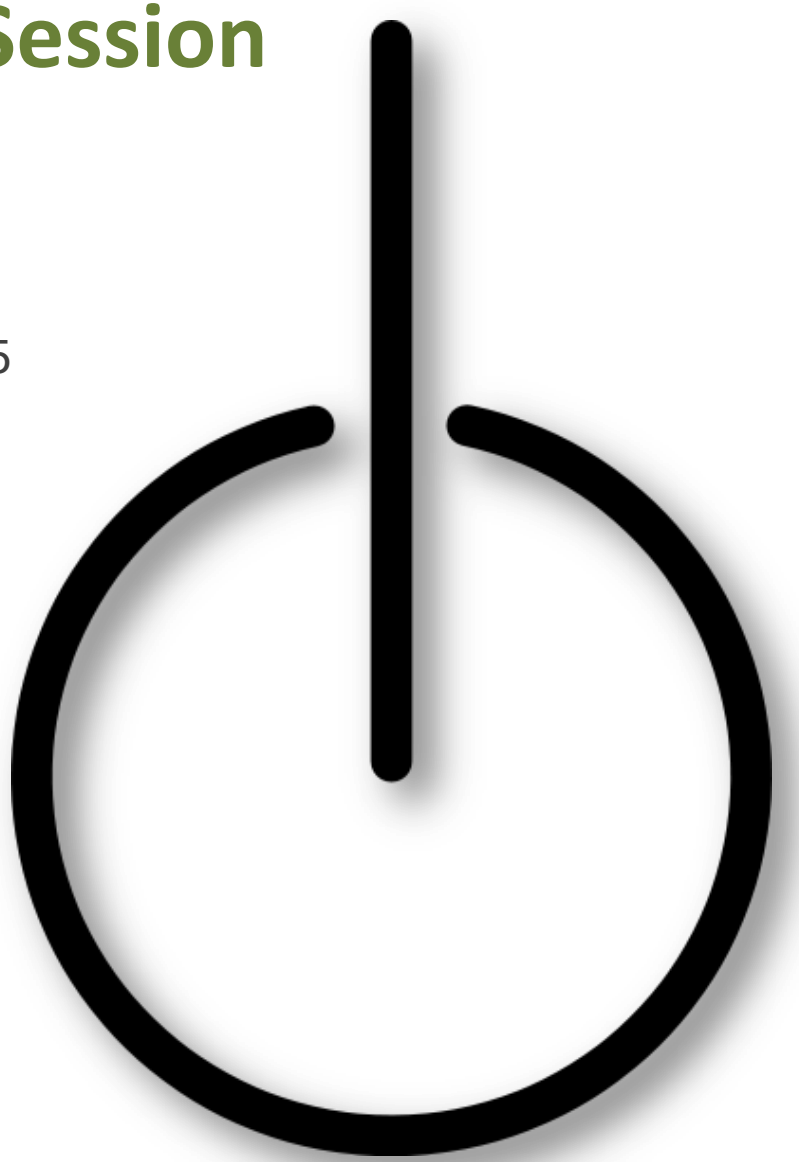
Overview of this Power Session

Session Agenda

Brief Affordable Care Act update/overview (5 mins)

Panel discussion (20 mins)

Facilitated audience discussion (15 mins)



Panelists

Breena Holmes, MD, Director, Maternal and Child Health, Vermont Department of Health

Cheryll Jones, RN, BSN, ARNP, CPNP, Health Services Coordinator, Ottumwa Regional Center of Child Health Specialty Clinics, Iowa

Affordable Care Act

Three Years in…

- Dependent coverage to age 26, no lifetime caps
- Prohibition on denying coverage to children with pre-existing conditions
- Pre-existing condition insurance plan for current uninsured
- Small business tax credits
- Premium review and rebates
- No cost-sharing for preventive services in new private plans and Medicare as well as for new

Affordable Care Act

In progress and to come in 2014

- Coverage becomes mandatory
- State decisions about health insurance exchanges
- State decisions about Medicaid Expansion – states can decide any time
- Federal regulations on many aspects of ACA operations, including exchange rules, plans rules, Medicaid eligibility

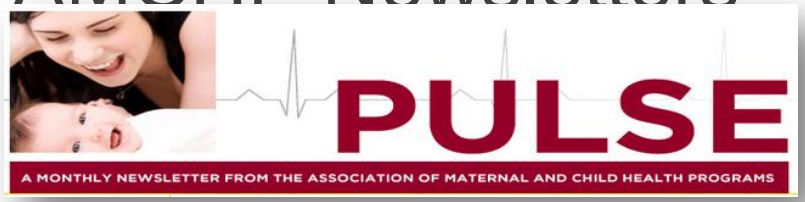
Health Reform Resources for States

AMCHP Website (www.amchp.org)

National Center for Health Reform Implementation

- Archived webinars
- Fact sheets and issue briefs

AMCHP Newsletters



Questions?

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